

§ 425.404

charges for primary care services furnished by—

(i) All ACO professionals who are ACO providers/suppliers in any other ACO; and

(ii) Other physicians, nurse practitioners, physician assistants, clinical nurse specialists who are unaffiliated with an ACO and are identified by a Medicare-enrolled TIN.

(b) [Reserved]

§ 425.404 Special assignment conditions for ACOs including FQHCs and RHCs.

CMS assigns beneficiaries to ACOs based on services furnished in FQHCs or RHCs or both consistent with the general assignment methodology in § 425.402, with two special conditions:

(a) Such ACOs are required to identify, through an attestation, physicians who directly provide primary care services in each FQHC or RHC that is an ACO participant and/or ACO provider/supplier in the ACO.

(b) Under the assignment methodology in § 425.402, CMS treats a service reported on an FQHC/RHC claim as a primary care service if the—

(1) NPI of a physician included in the attestation is reported on the claim as the attending provider; and

(2) Claim includes a HCPCS or revenue center code that meets the definition of primary care services under § 425.20.

Subpart F—Quality Performance Standards and Reporting

§ 425.500 Measures to assess the quality of care furnished by an ACO.

(a) *General.* CMS establishes quality performance measures to assess the quality of care furnished by the ACO. If the ACO demonstrates to CMS that it has satisfied the quality performance requirements in this subpart, and the ACO meets all other applicable requirements, the ACO is eligible for shared savings.

(b) *Selecting measures.* (1) CMS selects the measures designated to determine an ACO's success in promoting the aims of better care for individuals, better health for populations, and lower growth in expenditures.

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(2) CMS designates the measures for use in the calculation of the quality performance standard.

(3) CMS seeks to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both.

(c) ACOs must submit data on the measures determined under paragraph (b) of this section according to the method of submission established by CMS.

(d) *Patient experience of care survey.* For performance years beginning in 2014 and for subsequent performance years, ACOs must select a CMS-certified vendor to administer the survey and report the results accordingly.

(e) *Audit and validation of data.* CMS retains the right to audit and validate quality data reported by an ACO.

(1) In an audit, the ACO will provide beneficiary medical records data if requested by CMS.

(2) The audit will consist of three phases of medical record review.

(3) If, at the conclusion of the third audit process there is a discrepancy greater than 10 percent between the quality data reported and the medical records provided, the ACO will not be given credit for meeting the quality target for any measures for which this mismatch rate exists.

(f) Failure to report quality measure data accurately, completely, and timely (or to timely correct such data) may subject the ACO to termination or other sanctions, as described in §§ 425.216 and 425.218.

§ 425.502 Calculating the ACO quality performance score.

(a) *Establishing a quality performance standard.* CMS designates the quality performance standard in each performance year.

(1) For the first performance year of an ACO's agreement, CMS defines the quality performance standard at the level of complete and accurate reporting for all quality measures.

(2) During subsequent performance years, the quality performance standard will be phased in such that the ACO must continue to report all measures but the ACO will be assessed on performance based on the minimum attainment level of certain measures.

(b) *Establishing a performance benchmark and minimum attainment level for measures.* (1) CMS designates a performance benchmark and minimum attainment level for each measure, and establishes a point scale for the measures.

(2)(i) CMS will define the quality benchmarks using fee-for-service Medicare data.

(ii) CMS will set benchmarks using flat percentages when the 60th percentile is equal to or greater than 80.00 percent.

(iii) CMS reserves the right to use flat percentages for other measures when CMS determines that fee-for-service Medicare data are unavailable, inadequate, or unreliable to set the quality benchmarks.

(3) The minimum attainment level is set at 30 percent or the 30th percentile of the performance benchmark.

(c) *Methodology for calculating a performance score for each measure.* (1) Performance below the minimum attainment level for a measure will receive zero points for that measure.

(2) Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance.

(3) Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.

(4) Performance at or above 90 percent or the 90th percentile of the performance benchmark earns the maximum points available for the measure.

(d) *Establishing quality performance requirements for domains.* (1) CMS groups individual quality performance standard measures into four domains:

(i) Patient/care giver experience.

(ii) Care coordination/Patient safety.

(iii) Preventative health.

(iv) At-risk population.

(2) To satisfy quality performance requirements for a domain:

(i) The ACO must report all measures within a domain.

(ii) ACOs must score above the minimum attainment level determined by CMS on 70 percent of the measures in each domain. If an ACO fails to achieve the minimum attainment level on at

least 70 percent of the measures in a domain, CMS will take the actions describe in § 425.216(c).

(iii)(A) If the ACO achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings under subpart G of this part, the ACO may receive the proportion of those shared savings for which it qualifies.

(B) If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated.

(e) *Methodology for calculating the ACO's overall performance score.* (1) CMS scores individual measures and determines the corresponding number of points that may be earned based on the ACO's performance.

(2) CMS adds the points earned for the individual measures within the domain and divides by the total points available for the domain to determine the domain score.

(3) Domains are weighted equally and scores averaged to determine the ACO's overall performance score and sharing rate.

[76 FR 67973, Nov. 2, 2011, as amended at 78 FR 74823, Dec. 10, 2013]

§ 425.504 Incorporating reporting requirements related to the Physician Quality Reporting System Incentive and Payment Adjustment.

(a) *Physician quality reporting system.*

(1) ACOs, on behalf of their ACO provider/suppliers who are eligible professionals, must submit the measures determined under § 425.500 using a CMS web interface, to qualify on behalf of their eligible professionals for the Physician Quality Reporting System incentive under the Shared Savings Program.

(2)(i) ACO providers/suppliers that are eligible professionals within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of receiving an incentive payment under the Physician Quality Reporting System.